CALIFORNIA NATIONAL GUARD

Family Readiness

TEEN ADVENTURE Week

AUTHORIZATION FOR MEDICAL TREATMENT

I_____, as parent/guardian, authorize Emergency Medical
(Parent or Guardian)

Treatment for _____, a minor, in case of accident, illness or any
(Participant)

Other emergency requiring professional care during Teen Adventure Week activities. I understand that I will be responsible for any and all cost of such treatment.

Date_____ Signature_____
(Signature of Parent or Guardian)

MEDICAL INFORMATION

Name of family physician:_____

Phone Number:_____Address:_____

Name of insurance company:_____

Medical, group or member number:_____

Individual you wish contacted in case of emergency:

Name:_____

Phone Number:_____